No. 87-547

In the Supreme Court of the United States

OCTOBER TERM, 1987

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES OF KANSAS,
Petitioner,

vs.

AMERICARE PROPERTIES, INC. d/b/a Russell Kare Center and Ala Fern Nursing Home,
Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE SUPREME COURT OF KANSAS

BRIEF FOR THE RESPONDENT IN OPPOSITION

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QUESTIONS PRESENTED FOR REVIEW

I. Whether the overall objectives of Congress under Title XIX (Medicaid) and implementing regulations are aimed at assuring continuity of coverage as being in "the best interest of" the beneficiaries and recipients and, as such, they preempt the obstacle posed by the purported state law.

II. Whether the Department of Health and Human Services was acting clearly within the scope of its delegated authority in promulgating the regulation providing for automatic transfer of provider agreements in transfer of ownership situations.

PARTIES

The parties are:

Petitioner:

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES OF KANSAS.

Respondent:

AMERICARE PROPERTIES, INC., d/b/a Russell Kare Center and Ala Fern Nursing Home.

[THE KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT appeared as Amicus Curiae in the Supreme Court of Kansas proceedings.]

TABLE OF CONTENTS

TABLE OF AUTHORITIES

A. CASES:

B. STATUTES AND REGULATIONS:

Internal Revenue Regulations

C. OTHER AUTHORITIES:

STATEMENT OF THE CASE

The Respondent, Americare Properties, Inc., purchased two nursing homes in Russell, Kansas on September 30, 1984. At the time of the purchase, both homes were in operation and licensed under Kansas law as "adult care" homes of the "intermediate care" classification. They were providing care and services to some Medicaid eligible patients under existing medicaid Provider Agreements as certified medicaid providers at the time of the transfer of ownership.

In cases of a transfer of ownership of a licensed nursing home, licensure law requires the new owner to obtain a license, i.e.; the existing license is not transferable. Respondent applied for two new licenses which were subsequently granted on November 26, 1984. Petitioner, however, totally denied medicaid reimbursement for the period from October 1, through November 25, 1984, in the amount of $106,928.29 on the basis that "the Kansas medicaid program does not reimburse for adult care homes who are not licensed by the Department of Health and Environment" (the Kansas licensure agency).

On August 31, 1984, the former owners of the two nursing homes had notified the licensure agency, the Department of Health and Environment, of the impending sale of the homes and that agency responded with a letter dated September 10, 1984, which stated, in part, "as the current operator, you will be responsible for the operation of the facility until we issue a license to the new owner."

It was not disputed that respondent continued to provide proper care and services to the medicaid residents in the nursing homes during the period from October 1, 1984 through November 25, 1984, nor was there a dispute

over the amount that was to be paid under the terms of the Provider Agreements for the services rendered. There was no proceeding commenced to cancel or revoke the existing licenses of either home during this period. The reimbursement was denied based upon a document entitled a "Policy Memorandum" (see Appendix B) issued by Petitioner on March 15, 1984, which stated in part that "medical programs will not be reimbursed for services provided by an adult care home that is not licensed . . . . New owners will not be reimbursed for days that the facility is not licensed for (sic)."

The federal regulation involved here, which will be discussed hereinafter, was adopted by the Health Care Financing Administration of the Department of Health, Education and Welfare (now, the Department of Health and Human Resources) in 1980. In essence, it addressed the specific question of how to handle the matter of providing for medicaid payments in cases where there was a "change of ownership" of the nursing home, but for some reason not involving the denial of a license to the new owner, there was a potential "gap" in the licensure of the home due to particular state laws which did not allow a transfer of existing licenses.

The federal regulation resolved the issue by providing that there would be an automatic transfer of the provider agreements so as not to create a coverage gap for the medicare and medicaid beneficiaries and recipients, with all applicable state laws and regulations to continue to apply.

Respondent appealed the denial of reimbursement pursuant to state administrative remedy procedures, and an administrative hearing officer upheld the denial on the theory that, although the provider agreement did auto-

matically transfer as required by the federal regulation, it became, *eo instanti*, "null and void". This ruling was appealed to the state District Court which held that the federal regulation preempted the Petitioner's "policy memorandum", which ruling was subsequently upheld by the Kansas Supreme Court.

Respondent would disagree with statements in Petitioner's Statement of the Case that it (respondent) "changed staff" at the nursing home "since September 1", and that it did not identify for licensure the "administrator of one facility" or that it "failed" to submit ownership information. *Petition*, pp. 3, 4.

REASONS FOR DENYING THE WRIT

ARGUMENT

I. The Overall Objectives of Congress Under Title XIX (Medicaid) and Implementing Regulations Are Aimed at Assuring Continuity of Coverage As Being in "the Best Interest of" the Beneficiaries and Recipients and, As Such, They Preempt the Obstacles Posed by the Purported State Law.

This Court has frequently reiterated that state law is preempted if it "stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." *Pacific Gas & Electric Co.*, slip op. 11 (quoting *Hines v. Davidowitz*, 312 U.S. 52, 67 (1941)); *Fidelity Federal Savings & Loan Ass'n.*, 458 U.S. at 153; *Florida Lime & Avocado Growers, Inc. v. Paul*, 373 U.S. at 142-143; *Goldstein v. California*, 412 U.S. 546. When

Congress enacted the Medicaid provisions granting aid to the states for medical assistance programs it required the adoption in each state of an approved State Plan wherein federal regulations would be controlling. 42 U.S.C. §1396, et seq. While recognizing that necessary safeguards should be provided under the State Plan to assure eligibility for care and services, the Act further requires that such care and services be provided "in a manner consistent with simplicity of administration *and the best interests of the recipients.*" 42 U.S.C. §1396a(a)(19), emphasis supplied.

Therefore, the general underlying theme and *intent* of the Congress in enacting this legislation was to insure that the benefit of the *federal* funds granted reach the eligible beneficiaries and recipients and assure that the needed care and services be provided in the most efficient, simplified manner. This requirement of "in the best interest of" thus provides the general intent and basic purpose against which all the detailed federal and state law provisions involved in this case must be measured.

This petition involves a very narrow and confined factual circumstance which may arise in cases of a "change of ownership" of an existing, previously licensed and operating health care facility (in this case, two "intermediate care facilities"), where there is a temporary, technical gap in state licensure coverage arising between the time the former, licensed owner sells the facility and the new owner receives a new license. It does *not* involve a situation where there has been a *denial* of a license to the new owner, nor a *failure* to obtain a license in the first instance.

In this narrow type of factual setting, it is presumed that the new owner would *not* go to the considerable time,

effort and expense of purchasing an established nursing home without fully intending to and in fact proceeding to comply with all necessary requirements for continued operation of the home (as happened here). The federal agency charged with administering the medical and medicare laws (The Department of Health and Human Resources, herein "HHR") recognized from experience the practical problem that arises where a particular state's law requires a new owner to immediately obtain a new license, but there arises those inevitable cases where an administrative delay (not a *denial*) might occur in obtaining the new license. The question then arises as to whether this temporary situation should operate so as to automatically cut off benefits to the home and its already resident beneficiaries and recipients.

HHR has sought to *balance* the *general* recognition of the validity of state licensure law in the federal law (Social Security Act) with the *specific* intent of that law that the *best interests* of the beneficiaries and recipients should be served and simplicity of administration of the law preserved. It did so by the 1980 promulgation of 42 C.F.R. 442.14, providing that medicaid payments should continue during such temporary period, while recognizing that if the new owner is then *denied* a license, the payments may be terminated. This Court has held that in such cases, the inquiry becomes whether the federal agency's action " 'represents a reasonable accommodation of conflicting policies' ". *Fidelity Federal Savings and Loan Ass'n.*, supra, at 154.

HHR has implemented this underlying purpose and intent by duly adopted regulations which focus on this specific, narrow area involved where there is a *change in the ownership* of the health care facility without seek-

ing to "supercede" the overall state licensure requirements by requiring that payments continue under the existing "Provider Agreements." Provider Agreements are entered into between the appropriate state agency, in this case, the Kansas Department of Social and Rehabilitation Services (SRS) and the provider of the services, in this case, the two intermediate care facilities located in Russell, Kansas. These Provider Agreements are mandated by federal law and regulation as the vehicle or conduit by which the funds are transferred on down from the state to the particular providers of the care and services for the eligible medicaid beneficiaries residing in their facilities. Although the state was not required to participate in the medicaid program, once it has voluntarily elected to do so, it must comply with federal standards. *Country Club Home, Inc. v. Harder,* 228 Kan. 756, 620 P.2d 1140.

The Provider Agreements are normally entered into for a term of months, as required by federal regulation (42 C.F.R. Section 442.12), and in the present case the relevant Agreements were for the terms of June 1, 1984 through March 31, 1985 (Ala Fern Nursing Home) and July 1, 1984 through June 30, 1985 (Russell Kare Center) respectively. Thus, the stated terms of the two Agreements completely envelope the payment period which SRS sought to dispute and deny, i.e.; the seven and one half week period from October 1, 1984 through November 25, 1984, the day before the licenses were later granted by SRS, with no claim made by SRS that proper care and services were not furnished during the interim period.

In 1980, HHS duly promulgated regulations which, in part, carefully addressed this "transfer of ownership" situation vis-a-vis existing Provider Agreements. See 42

C.F.R. 442.14. Specifically, as shown by the plain wording of the Regulation itself, as well as by the comments quoted in the Federal Register as part of the agency's proposed ruling making procedure (see *Federal Register*, Vol. 45, No. 67, pp. 22933 through 22935, attached hereto as Appendix A), HHS was consciously concerned about any gap which might result in a "change of ownership" situation if payments under Provider Agreement or payments thereunder were interrupted or terminated solely by reason of such ownership change.

This concern by HHS clearly centered upon "protecting beneficiaries" from possible adverse effects of any such "coverage gap", by providing for an *automatic assignment* of the Provider Agreement. This concern will be further demonstrated by the quotations and discussion below. At the same time, it is readily apparent that the federal agency sought to craft the new regulations in such a way as to permit and preserve legitimate safeguards for the protection of the "health and safety" of the Medicaid beneficiaries during change of ownership situations. The Regulation was patently drawn by HHS to carry out the overriding concern and mandate of the Federal Act and Congress to protect "the best interests of the recipients" by, on the one hand, avoiding "interruption of coverage", and, on the other, by providing or recognizing the continued applicability of safeguards *reasonably related* to protecting the "health and safety" of the residents and decreasing the "risk of fraud and abuse". This 1980 Regulation provided:

> §442.14 Effect of change of ownership.
>
> (a) *Assignment of agreement. When there is a change of ownership, the Medicaid agency must automatically assign the agreement to the new owner.*

(b) *Conditions that apply to assigned agreements.* An assigned agreement is subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued, including, but not limited to, the following:

(1) Any existing plan of correction.

(2) Any expiration date.

(3) Compliance with applicable health and safety standards.

(4) Compliance with the ownership and financial interest disclosure requirements of §§455.104 and 455.105 of this chapter.

(5) Compliance with civil rights requirements set forth in 45 CFR Parts 80, 84 and 90.

(6) Compliance with any additional requirements imposed by the Medicaid agency.

45 F.R. 22933, dated April 4, 1980. Emphasis supplied.

An analysis of the above Regulation shows that it serves the two objectives cited above in that subpart "a" averts the detrimental "coverage gap" in payments by mandating an automatic transfer of the Provider Agreement to the new owner, while subpart "b" preserves and recognizes all the other terms and conditions of the Agreement originally issued, including compliance with health and safety standards and existing plans of corrections. The Regulation also preserves recognition of the existing expiration date, and explicitly recognizes the need of the new owners to pursue compliance with requirements for ownership and financial disclosure requirements as well as civil rights compliance.

It is also pointed out that this Regulation makes reference to the Federal Register, 45 F.R. 22934, dated April 4, 1980, which is set out in part in Appendix "A" attached hereto. The Federal Register states in numbered paragraph 2, as follows:

> "2. *Assignment of Provider Agreement Where There Is A Change of Ownership.* Under the proposed rules Medicare and Medicaid Provider Agreements would be automatically assigned to the new owner, subject to all the terms and conditions under which the original agreement was issued. *This approach would make Medicare and Medicaid practices uniform."* Emphasis supplied.

Further analysis of comments in the Federal Register relevant to automatic changes of ownership shows the HHS expressly addressed and considered concerns about the "automatic transfer" provision in change of ownership situations:

> "*Analysis of Public Comments*:
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> We received 24 comments on the February 5, 1979 Notice of Proposed Rulemaking. Most comments were favorable and recognized the need for the regulations. They were addressed primarily to whether the effective date of provider agreements should be based on the onsite survey date or the date of request for participation; whether the effective date rules apply only to initial certifications; *whether assignment should be automatic on change of ownership; and whether assignment conflicts with other regulations."* Introduction and para. 2, 45 F.R. 22934; Emphasis supplied.

And, in responding to a question regarding whether or not the assignment of the provider agreements would be automatic, the Department of Health and Human Services said as follows:

> "* Some State laws prohibit transfer of a license to a new owner. A new license is issued only after an onsite inspection. Since Federal regulations require compliance with State and local laws, some States would be violating their own rules." Id., at p. 22935.

Continuing, the Federal Register states:

> "Response: We realize that the State survey agency often learns of a change of ownership after the fact. We also acknowledge that there may be some unscrupulous owners who might take advantage of the situation. But we do not agree that this is the norm. Our primary goal is to protect beneficiaries and recipients against interruption of coverage. We believe the following safeguards will protect their health and safety and decrease the risk of fraud and abuse."
>
> * "The regulations do not prevent the State survey agency from going in at any time either under the Medicare/Medicaid authority or the authority of State licensure laws."
>
> * "All providers are required to be in compliance with State and local laws as a condition of participation. If the State, *after a licensure survey* refuses to issue a license because of non-compliance with State law, the facility would no longer be eligible to participate in the Federal programs. *It must be remembered that the regulation refers to transfers of provider agreements and not to transfers of State licenses.*" Id., p. 22935; emphasis supplied.

It is clear from the above legislative history of the adoption of this Regulation that HHS gave specific and careful consideration of all the various factors and concerns involved, and then deliberately opted for the approach now reflected in 42 C.F.R. 442.14, quoted above. In so doing, HHS was acting within the manifest intent of Congress to protect the "best interests" of the welfare recipients in these health care institutions. As noted, its action deals expressly with transfers of a *provider agreement* in the narrow circumstance of a change of ownership; it does not deal with or impact in any substantive manner with the matter of state licenses or the transfer thereof. As such, this Regulation and the Congressional intent which it serves clearly preempts any contrary state law, regulation or "policy" statement.

It is likewise obvious that the purported "Policy Memorandum" prepared in 1984 by the Kansas Department of Social and Rehabilitation Services stands as an "obstacle" to and directly "frustrates" the accomplishment and execution of the intent of the federal law and this regulation. *Pacific Gas and Electric Co.*, supra; *Savage v. Jones*, 225 U.S. 501.[1] This "policy" statement purports to deny any medicaid reimbursement to new owners of licensed facilities during any "gap" period which might occur between the date that ownership of the facility is transferred as between the former, licensed owner and the "new owner" and the date that the new owner receives the new

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1. State laws "may not frustrate the operation and purpose of federal law". *Savage v. Jones*, 225 U.S. at 507. The Chief Hearing Officer who conducted an administrative hearing within the state agency sought to *avoid* the conflict by the sophistry of declaring that the provider agreements were "automatically assigned to the new owners" but *once assigned* "became null and void", thus neatly eviscerating the whole purpose of the federal regulation. *Petition*, p. A24.

state license for the faciilty. Therefore, the "policy memorandum", which is most arguably not authorized under state law as well (see discussion below), flies directly in the face of the deliberate federal policy to avoid "coverage gaps" in medicaid reimbursement for non-substantive reasons arising solely from legal transfers of ownership, where no threat to the health and safety of medicaid residents is involved.[2] Application of the federal preemption doctrine under the Supremacy Clause of the United States Constitution (Article VI, cl. 2) is clearly called for in this situation, and the Kansas Supreme Court and Kansas District Court correctly so ruled.

A. The Federal Preemption Doctrine Applies Equally to Validly Adopted Federal Regulations Such As 42 C.F.R. 442.12.

Although the overall intent of Congress to protect the "best interests" of the medicaid beneficiaries arises from the language of the federal statute, and that language would be *per se* sufficient to preempt the state policy memorandum involved here, it is also true that the Federal Regulation involved (42 C.F.R. 442.12) has the same force and effect as a federal law in terms of the application of the federal preemption doctrine. As this Court stated in *Fidelity Savings and Loan Ass'n.*, 458 U.S. at 153: "Federal regulations have no less preemptive

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2. Of course, if a threat to the health and safety of the residents exists or arises during the time of the transfer of ownership and transfer of licensure period, the state has ample tools available to take appropriate corrective action; denial of medicaid reimbursement during such periods obviously is not aimed at nor would it bear any reasonable relationship to preventing such threats to health and safety. If anything, just the opposite would be true, i.e. cutting off needed funds might impair the facilities' ability to adequately care for the residents.

effect than federal statutes." See also *Blume v. Bacon,* 457 U.S. 132 (1982); *Free v. Bland,* 369 U.S. 663, 668 (1962); *United States v. Shimer,* 367 U.S. 374, 381-382 (1961). The Secretary of Health and Human Resources has been delegated authority to promulgate rules and regulations to carry out the purpose and intent of the federal statute. The particular regulation involved here (42 C.F.R. 442.14) falls within the scope of the delegated authority of the Secretary to make rules and regulations to carry out the overall intent that the "best interests" of the welfare recipients be served by the program.

The Petitioner complains that the Supreme Court of Kansas "considered *only* particular *regulation* intents (sic) to rule that 42 C.F.R. and its subsection (a) superceded stated licensure requirements . . . ." *Petition,* p. 8; emphasis by Petitioner and in part added; material in parentheses supplied.

The *implication* from the above quoted language appears to be that federal *regulations,* and the clear *intent* of *their* language, are of *lesser* stature that federal laws, and therefore may be safely ignored or disregarded in analyzing whether there is federal preemption on a particular matter. As noted above, validly adopted federal regulations promulgated by the agency charged with the responsibility of carrying out the broad intent of Congress, are of *equal* force and effect with federal statutes in cases involving federal preemption.

Further, the Petitioner virtually admits, *sub silentio,* that a full and fair reading of the federal regulation and the accompanying legislative history as set forth in the Federal Register clearly demonstrates the HHS consciously and deliberately addressed the precise question

involved here—how to handle possible coverage gaps in medicaid payments under provider agreements in cases of ownership changes—and then it proceeded to resolve the question *adverse* to Petitioner's position here. Consequently, Petitioner seeks to duck the inevitable preemption consequence by somehow *demoting* federal regulations and their clearly expressed intent to some lesser status where, presumably, the preemption doctrine does *not* apply, even though there is a manifest conflict between the intent of the federal *regulation* and the state agency's "policy".

However, Petitioner does seek to rely upon a *selected* "part" of the comments and legislative history surrounding the 1980 adoption of the federal regulation contained in the Federal Register which Petitioner, erroneously, construes as supporting its position.

Petitioner argues that "*Part* of that (Federal Register) comment when considered with the statutory language of 42 U.S.C. §1396d(c) should be *controlling.*" *Petition*, p. 11; material in parenthesis and emphasis supplied. Thus, Petitioner studiously ignores and avoids any quotation from or discussion of these *specific* comments in the Federal Register which squarely address and resolve (adversely to Petitioner) the continuation of payments question in owner transfer cases where there is non-substantive, administrative gap in licensure (see quotation from Federal Register, Appendix "A"). The Federal Register "comment" which Petitioner does selectively single out and promote as "controlling" is the statement that: "It must be remembered that this regulation refers to *transfers of provider agreements* and *not* to *transfers of State* licenses.[3]

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3. *Petition*, p. 11, emphasis supplied; quoting from 45 F.R. 22935 (Apr. 4, 1980), and referring to the adoption of 42 C.F.R. 442.14(a).

Exactly! This comment, properly read along with the entire context of the comments accompanying the promulgation of the Regulation, clearly supports the position of the respondent here, rather than that of Petitioner.

As discussed above, the entire Regulation was carefully crafted to avoid, on the one hand, any conflict with or limitation on state *licensure* requirements while, on the other hand, carrying out the Congressional intent to protect the best interests of the medicaid recipients in cases of ownership transfer by providing for automatic *provider agreement* transfer (*not* license transfer) to avoid detrimental coverage gaps while the administrative procedure for the issuance of new licenses was being accomplished. The above quoted comment from the Federal Register simply points out this carefully circumscribed focus of the new Regulation aimed at *provider agreements only*, while disclaiming any intent to affect state licensure laws.

B. The Automatic Transfer of Provider Agreement Provisions of 42 C.F.R. 442.14(a) Do Not Purport to Preempt or Control State Licensure Laws Regarding Intermediate Care Facilities.

Petitioner's entire approach to this matter is based on an effort to posit this case on the ill founded supposition that the state licensure laws would be preempted or superceded by the HHS Regulation if provider agreements and payments thereunder are automatically continued during the relatively brief time frame when change of ownership procedures are taking place.[4]

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4. The Petitioner argues that "(n)one of (the) statutory and regulation (sic) framework indicates either an intent to preempt State licensure laws or to deprive medicaid recipients of their protections from (sic) such laws." *Petition*, p. 14; material in parentheses supplied.

The Petitioner charges, incorrectly, that the Kansas Supreme Court has *ruled* that the federal regulation "superceded state law *licensure requirements*", and then it proceeds to argue vehemently throughout that this case involves "preemption of state law *licensure* requirements".[5] Such is simply not the case; both the federal regulation involved and the Kansas Supreme Court decision construing and applying it focus solely on the very narrow and specific matter of transfer of *provider agreements* (not *state licenses*) in "change of ownership" procedures.

The Kansas Supreme Court properly analyzed the automatic transfer provisions of the federal regulation and found its "principal purpose" as "being to provide continued services for beneficiaries and recipients, and guard them against interruption of coverage" (*Petition*, p. A49). The Kansas Supreme Court also took due note of the fact that this federal regulation provides that "assigned agreements are subject to all applicable statutes and regulations and to the terms and conditions under which the original agreement was issued." (*Petition*, p. A47). The subject Regulation expressly notes six of these limiting conditions which continue to apply *after* the automatic assignment takes place, which list is not to be considered exclusive. See *Petition*, pp. 10, 11, for list.

The provisions which by federal regulation continued to apply to any automatic assignment carefully preserve those substantive provisions in the provider agreements relating to the health, safety and welfare of the residents,

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5. *Petition*, pp. 8, 10; emphasis added; at p. 13, Petitioner argues, without any rational factual foundation and contrary to existing statutes, that the federal regulation "leaves them without the protection of basic licensure requirements that are to be accorded to all other nursing home patients in the state."

while also addressing related concerns about ownership and financial interest disclosure, as well as civil rights.

The federal regulation was thus clearly worded so as not to restrict or preempt applicable state *licensure* statutes and regulations designed to protect the welfare of the beneficiaries and recipients. Further, promulgation of this federal regulation did not seek in any manner to impair the overall state policy that makes it "unlawful" to operate a nursing home facility without a license (K.S.A. 39-926). The Kansas Supreme Court opinion specifically recognizes the continued efficacy of this statute and additionally cites specific enforcement provisions or "teeth" in the Kansas statute, which make it a misdemeanor subject to fine and jail sentence to operate a nursing home (adult care home) without a license. (*Petition,* p. A47). The opinion notes also the state statutory provision that *licenses*[6] are not transferable, and that new owners are required by state regulations "to apply for" new provider agreements.

While the regulation of the Kansas Department of Social and Rehabilitation Services specifies that where there is a "change of provider" or a "change of ownership" of an adult care home having an existing provider agreement, an application to be a provider "shall be *submitted*" (K.A.R. 30-10-1b [b] and [c]), this regulation does not purport to say that payments under the *existing provider agreement* cease either automatically or within a set period of time, if a new provider agreement is not applied for or received by the exact date of the owner-

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6. The non-transferability statute (K.S.A. 39-928) refers specifically to "licenses", *not* to "provider agreements."

ship "change". All this regulation commands is that the new provider/owner "submit an application".[7]

This regulation was *properly* promulgated by SRS in accordance with the Kansas law requiring all administrative rules and regulations which seek to have "the effect of law" and to "govern" an agency's "enforcement or administration of legislation" to be adopted in a specified manner. This required procedure includes scrutiny by the state Department of Administration, a review for legal sufficiency by the Attorney General, notice to interested parties of a hearing and a hearing thereon. K.S.A. 77-415, et seq.

By contrast, the "Policy Memorandum" at issue here was *not* adopted by SRS in accordance with the above cited law governing promulgation of rules and regulations having "the effect of law", and it therefore falls into the subordinate category of being merely an "interpretation" of existing law (see K.S.A. 77-415 [4]). As such, this "Policy Memorandum" appears to be in direct conflict and inconsistent with the duly adopted state regulation cited above (K.A.R. 30-10-1b).

Therefore, a strong argument may be made that (1) the "Policy Memorandum" involved here does not even rise to the level of being a *state law* or *regulation* such as would trigger a preemption analysis of federal-state conflict of law under the Supremacy Clause, and (2) the "Policy Memorandum" itself is in conflict with a duly

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7. The Regulation does require either the "seller or prospective buyer to notify the agency at least sixty (60) days in advance of the proposed changed ownership", but the penalty for failure to notify is specific and limited to the "new owner assuming responsibility for any overpayment made to the old owner".

adopted state law (i.e.; SRS regulation 30-10-1b) which specifically covers and controls the subject of *provider agreements* (not state *licenses*) and changes of ownership.

Consequently, this entire dispute may well be resolved against Petitioner on a non-constitutional basis as a matter of the interpretation and interaction of purely state statutes and regulations, without even having to resort to resolution of a *constitutional* issue under the Federal Supremacy Clause. Treating the matter as a question of statutory interpretation without reaching a constitutional issue is, of course, the preferred handling of such cases. *Douglas v. Seacoast Products, Inc.*, 431 U.S. 265.

In addition to the various tools for enforcement of the state *licensure* mentioned by the Kansas Supreme Court which remain completely unscathed or unaffected by the federal regulations, there are a multitude of other state provisions for enforcement of laws relating to the licensed facilities, including (1) "injunctions or other process to restrain or prevent the operation of an unlicensed adult care home (K.S.A. 39-944), (2) the issuance of "correction order" in any case where "health, safety, nutrition or sanitation" is adversely affected, which order "shall specify *the time allowed for correction*"[8] (K.S.A. 39-945; emphasis supplied), (3) issuance of a "citation" and imposition of a monetary "civil penalty" for failure to correct deficiencies (K.S.A. 39-946) and (4) appointment of a "receiver" to

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8. Interestingly, the state statute implicitly acknowledges that even in cases where a violation imperiling "health or safety" is discovered, some reasonable *period of time* shall be allowed for correction thereof, and the implementing regulations permit up to six months or a year to accomplish compliance.

take over the operation of the home where (a) conditions that are life threatening or endangering exist, (b) insolvency or (c) license revocation by the secretary of health and environment. K.S.A. 39-954.

Against this backdrop of multiple licensure enforcement tools available—criminal prosecutions, injunctions, citations, civil penalties, receivership, licensure denial (for cause) and other means of control—the hollow claim of the Petitioner that this decision of the Supreme Court regarding its policy memorandum will "deprive Medicaid recipients of their protections from (sic) such (licensure) laws"[9] is simply empty rhetoric and wildly overblown. The intent of the federal regulation clearly recognizes that if the new owner's application for a license is subsequently *denied* for some substantive or valid reason, then continued provider payments may be terminated.[10]

It is not necessary that a federal law, either statute or regulation, contain an express provision manifesting an intent to preempt conflicting state laws, in order for the preemption doctrine to apply. *DeCanas v. Bica,* 424 U.S. 351. Even though there is no express statement in the federal law or regulation involved requiring automatic transfer of provider agreements which states in so many words that all state laws or regulations to the contrary are preempted, the doctrine nonetheless applies if the state law "frustrates" or creates an "obstacle" to the federal purpose—in this case, protecting the health, safety and best interest of the medicaid beneficiaries by preventing

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9. *Petition,* p. 14; emphasis supplied.

10. See *Comments* from Federal Register, Appendix A, p. A3.

a gap in coverage. Preemption may be either express or implied. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85.

Petitioner argues that the federal law "hardly indicates any intent for preemption of state licensure requirements."[11] This is plainly a further attempt to mis-characterize the scope of the federal regulation as some type of broad scale "attack" on state "licensure requirements" and then fight the case on a "battlefield" different from that actually presented under the facts and law. This regulation addresses the very narrow and limited issue of whether medicaid payments should or should not continue so as to cover any gap in coverage that might otherwise arise in the transfer of ownership administrative procedure. It is obvious from the comments accompanying the adoption of the regulation that the federal agency was cognizant of a potential conflict and it consciously resolved any such perceived conflict in favor of the overriding Congressional intent to protect the best interests of the medicaid recipients. Thus, an overt, *clearly expressed intent* to preempt in this narrow area is present in the federal regulation.

Both the state District Court and the Kansas Supreme Court clearly recognized the narrow and non-substantive area in which the federal regulation was intended to preempt state law: the District Court noted that it applied *only* to situations in which there might be a simple "delay" in getting a license, not a refusal of state licensure."[12] The Supreme Court referred to the limited situation as one where a new owner applicant might be "tardy" in apply-

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11. *Petition*, p. 9.

12. *Petition*, p. A37.

ing for the license, but nonetheless meet "those requirements".[13]

Both Kansas courts recognized the situation as one not involving any substantive threat to the health, safety or welfare of the residents, but one where the state agency, in a type of bureaucratic pique over "tardy" new owner applicants, was seeking to "punish" *them* for their delay in applying for a licensure replacement, by an irrevocable cancellation of provider payments during any such interim period (without regard to the possible "punishment" of medicaid recipients which might occur).

The Department of Health and Human Resources clearly anticipated the possible "conflict" that might arise in the limited *ownership transfer* situation. Without harming the basic state licensure structure in any way, the federal agency nevertheless "manifested" a clear intention to override any state law or policy which might be involved to "frustrate" the clear congressional mandate given the agency to protect the welfare of the medicaid recipients.

C. The Kansas Department of Social and Rehabilitation Services Lacked Jurisdiction to Issue the Policy Memorandum Ostensibly Aimed at Enforcing State Licensure Laws Administered by the Department of Health and Environment.

The licensing agency in the State of Kansas which issues and controls licenses for intermediate care facil-

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13. *Petition*, p. A48; the purported agency "policy", however, was more broadly drawn and would operate to automatically terminate provider payments in a situation where, for example, a sole proprietor licensee was unexpectedly killed in a car accident, thus cancelling the old license.

ities (adult care homes) is the Department of Health and Environment, acting through its Secretary (K.S.A. 39-923[a] [14]):

"39-923(a) As used in this act:

* * *

(14) 'Licensing agency' means the secretary of health and environment."[14]

The Petitioner in this case, however, is the Department of Social and Rehabilitation Services of Kansas (SRS), a separate state agency.[15] It is this agency (SRS), and *not* the state licensure agency, the Department of Health and Environment (KDHE), which issued the "Policy Memorandum" involved here.

Petitioner, the Department of Social and Rehabilitation Services, neither issues, renews, denies, suspends or revokes licenses issued to "intermediate care facilities", nor does it otherwise control or regulate the state licensure laws procedure. Nevertheless, Petitioner has elected in its Petition to base its request for the granting of a writ of certiorari on the sole argument that the 1980 federal regulation involved threatens and attempts to "supersede state law licensure requirements" contrary to "Congressional intent".[16] Petitioner insists that it is for

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14. See Chapter 75, Article 56, Kansas Statutes Annotated, for laws creating and regulating the Department of Health.

15. See Chapter 75, Article 53, for law creating and regulating the Department of Social and Rehabilitation Services.

16. Petitioner's argument in support of its reason for granting the writ commences:

> "Neither the opinion of the Supreme Court of Kansas, nor the affirmed and quoted opinion of the state District Court consider the provisions of 42 U.S.C. 1396d(c) and its recognition of the requirement to be "licensed under State law" before construing a subordinate federal regulation to supersede state law licensure requirements." *Petition*, p. 7.

this reason, i.e.; protecting the "state *licensure* procedures," that it issued its March 15, 1984 "policy memorandum" cutting off medicaid payments in situations where a new state license was not issued for an existing facility on or before the date of an "ownership change".

However, the appropriate state agency to promulgate regulations (or "policies") enforcing the state licensure laws would be the licensing agency itself, the Department of Health and Environment. That state agency did not see fit to promulgate or, at a minimum, cosponsor such a regulation.

Consequently, SRS *lacked jurisdiction* to promulgate a regulation or policy under the guise or purported authority of "protecting" the "state licensure laws". This further illustrates the transparency of Petitioner's ill founded claim that the federal regulation "superceded" state license requirements, which it (SRS) was seeking to enforce.

II. The Department of Health and Human Services Was Acting Clearly Within the Scope of Its Delegated Authority in Promulgating the Regulation Providing for Automatic Transfer of Provider Agreements in Transfer of Ownership Situation.

The Department of Health and Human Resources (formerly Health, Education and Welfare) was acting clearly when the scope of its delegated authority to promulgate rules and regulations designed to carry out the Congressional intent that the Medicaid and Medicare programs protect the "best interests" of the beneficiaries and recipients under a joint federal state program to be carried out in a simple and efficient manner. 42 U.S.C. §1396a(a)(19). Petitioner claims a lack of "power" on

the power of HHR to have promulgated the regulation in question, ostensibly asserting a lack of congressionally delegated authority. The agency is expressly granted authority to promulgate rules and regulations, and this particular regulation is firmly premised on the intent of Congress to protect in the last analysis the welfare and best interests of the beneficiaries and recipients of these federally supported programs.

Petitioner likewise chastises the Kansas Supreme Court for its alleged failure to "address" the question of whether Congress intends that the federal regulation supercede state law and to "address" a *presumption* that "matters related to health and safety" are not to be superceded by federal law, citing two United States Supreme Court decisions, *Louisiana Public Service Comm. v. FCC*, 476 U.S. ....., 106 S. Ct. 1890; *Hillsborough County v. Automated Med. Labs*, 471 U.S. 707.

While respondent has no quarrel with the general proposition of law stated in those two decisions, neither is apropos on the facts or law to the situation involved in this application for writ. Petitioner has simply attempted to select the wrong battleground on which to fight this case. Having wrongly characterized this case as one in which the federal regulation seeks to overthrow or "supercede" state licensure requirements on the one hand, while mistakenly identifying its purported "policy" as being designed to "protect" the "health and safety" of beneficiaries and recipients,[17] Petitioner then proceeds to argue from cases not applicable to the matter at hand.

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17. Just the opposite is true, cutting off medicaid support for no reason related to any showing of a threat to the health or welfare of the recipients potentially imperils their welfare, as previously discussed.

Obviously, both the Kansas Supreme Court and the state District Court took a careful look at the intent of Congress, quoting not only the particular regulation adopted but also citing comments accompanying its promulgation which made it clear that automatic transfer of provider agreements was the desired intent and option elected, soundly based on the desire to protect the best interests of the welfare recipients.

By the same token, the Supreme Court opinion also recognized and confirmed the "health and safety" aspects of the case and concluded that the interests of the recipients and beneficiaries outweighed the spuriously adopted policy of SRS to "prod new owners into prompt action"[18] on a non-substantive, administrative procedure. In so doing, the Supreme Court pointed out specfically that it was the *state* agency which was ignoring or seeking to avoid the clearly expressed federal intent in the matter, to-wit: "(T)he (SRS) policy does not appear to take into account the principal purpose of the federal regulation: to provide continued services for beneficiaries and recipients, and guard them against interruption of services."

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18. *Petition*, p. A49.

CONCLUSION

The Department of Health and Human Resources promulgated the regulation involved here with the clear intent of carrying out the Congressional mandate to protect the best interest of the medicare and medicaid beneficiaries and recipients. It had the lawfully delegated authority to do so in a simplified administrative program. Its regulation is aimed at a very narrow, factual situation and does not threaten or impede overall state licensure requirements. The state "policy" involved is of questionable validity under state law, and was beyond the jurisdiction of the particular state agency involved.

For the reasons stated above, the Petition For Writ of Certiorari should be denied.

Respectfully submitted,

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APPENDIX

APPENDIX A

Federal Register

Vol. 45, No. 67 / Friday, April 4, 1980 / Rules and Regulations

(Pages 22933-22935)

* * *

SUMMARY: These regulations revise and redesignate the policies pertaining to provider agreements under the Medicare program to simplify them and to make them easier to read. We have made substantive changes only in the provisions relating to the effective date of the agreement and the effect of a change in ownership. These substantive changes were issued as proposed rulemaking on February 5, 1979, and will also apply to the Medicaid program.

* * *

* * * The revised regulations also provide that existing provider agreements be assigned to new owners, subject to the terms and conditions under which they were originally issued.

The intent of the substantive changes is to achieve maximum uniformity of policy for the two programs and to provide continuity of coverage for beneficiaries and recipients when there is change of ownership.

* * *

Medicare and Medicaid had developed different practices for the effective date of provider agreements. * * * These revised rules establish uniform policy on effective dates.

Medicare and Medicaid also dealt differently with changes of ownership. Both Medicare and Medicaid issued new agreements. However, Medicare permitted the agreement to be backdated to the date the previous agreement was terminated. Under Medicaid, a new survey was usually made and a new agreement issued effective on the date compliance was determined. The difference could result in a coverage gap for Medicaid recipients. These revised rules provide for assignment of agreements to new owners in both programs.

* * *

2. *Assignment of Provider Agreement When There Is Change of Ownership.* Under the proposed rules, Medicare and Medicaid provider agreements would be automatically assigned to the new owner, subject to all the terms and conditions under which the original agreement was issued. This approach would make Medicare and Medicaid practices uniform. * * *

* * *

Analysis of Public Comments:

We received 24 comments on the February 5, 1979, Notice of Proposed Rulemaking. Most comments were favorable and recognized the need for the regulations. They were addressed primarily to whether the effective date of provider agreements should be based on the onsite survey date or the date of request for participation; whether the effective date rules apply only to initial certifications; whether assignment should be automatic on change of ownership; and whether assignment conflicts with other regulations.

* * *

Response: The regulations have been modified to clarify that in recertification of long-term care providers,

the new agreement becomes effective when the existing agreement expires. * * *

* * *

* Some State laws prohibit tranfer of a license to a new owner. A new license is issued only after an on-site inspection. Since Federal regulations require compliance with State and local laws, some States would be violating their own rules.

* * *

Response: We realize that the State survey agency often learns of a change of ownership after the fact. We also acknowledge that there may be some unscrupulous owners who might take advantage of the situation. But we do not agree that this is the norm. Our primary goal is to protect beneficiaries and recipients against interruption of coverage. We believe the following safeguards will protect their health and safety and decrease the risk of fraud and abuse.

* * *

* The regulations do not prevent the State survey agency from going in at any time either under the Medicare/Medicaid authority or the authority of State licensure law.

* * *

All providers are required to be in compliance with State and local laws as a condition of participation. If the State, after a licensure survey, refuses to issue a license because of non-compliance with State law, the facility would no longer be eligible to participate in the Federal programs. It must be remembered that this regulation refers to transfers of provider agreements and not to transfers of State licenses.

* * *

APPENDIX B

POLICY MEMORANDUM

TO: James G. Hall, EDS-Federal

FROM: L. Kathryn Klassen, R.N., M.S.

DATE: February 21, 1984

RE: Policy Non-Payment of ACH's not Licen

Rate Change

Control # 406

Processing Procedure

Effective 3-15-84, Medical Programs will not reimburse for services provided by an Adult Care Home that is not licensed. According to State Law, all Adult Care Homes have to be licensed in order to be reimbursed. New owners will not be reimbursed for days not licensed.

Rationale for change:

Federal regulations require states to transfer the previous owners provider agreement whenever a change of ownership occurs. State regulations require a facility to be relicensed whenever a change of ownership occurs.

Recently, we have had several providers who have called and stated "we took over 2-1-84," and the Dept. of Health & Environment has not licensed their facility because they got notice of the change the same time SRS did. (Continued On Reverse Side)

The following will become effective _____ service date or _____ processing date; requiring ____ provider notification, ____ provider manual change, _____ Medical Assistance manual change, ____ processing manual change.

Effedtive 3-15-84, Medical Programs will not reimburse for services provided by an Adult Care Home that is not licensed. According to State Law, all Adult Care Homes have to be licensed in order to be reimbursed. New owners will not be reimbursed for days that the facility is not licensed for.

3-2-84
Date

L. Kathryn Klassen
L. Kathryn Klassen, R.N,M.S.
Director of Medical Programs

Sent to:

	Yes	No	Comments Made:
IM Chiefs	☐	☐	
SS Chiefs	☐	☐	
Area Managers	☐	☐	

Policy Committee Action: Approved 2/28/84

John Schneider
John Schneider, Commissioner
Income Maintenance & Medical Services